2010 WL 4110553 (La.App. 4 Cir.) (Appellate Brief)
Court of Appeal of Louisiana, Fourth Circuit.

Ericka GEORGE, Plaintiff-Appellant,

v.

LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS, Defendant-Appellee.

No. 2010-CA-1124.
September 28, 2010.

On Appeal from the Civil District Court, Parish of Orleans, Honorable Piper D. Griffin, District Judge, Division "1-14," No. 2007-12685

Original Brief on Behalf of the Louisiana State Board of Practical Nurse Examiners, Defendant-Appellee

Appeal Counsel for Appellee, Francis B. Mulhall, LSBA No. 17502, 3900 N. Causeway Blvd., Suite 1470, Metairie, Louisiana 70002, Telephone: (504) 836-7536, Counsel for the Louisiana State Board of Practical Nurse Examiners.

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1 *I. STATEMENT OF THE CASE

The Louisiana State Board of Practical Nurse Examiners (the "Board"), whose mission is to protect the public health and welfare through regulation of practical nursing education and practice, received a complaint concerning the nursing practices of Ericka George, LPN (sometimes referred to as "Respondent"). In particular, the Board received a report indicating the respondent, while working at the Rayne Guest House, did not respond appropriately to a resident's declining condition. Numerous requests were made from family members, for the respondent to assess the resident's pain and difficulty breathing; however, the respondent failed to do a thorough assessment by failing to include vital signs. The respondent stated to the family members that nothing was wrong with the resident (Ms. Lavergne). After the resident's granddaughter made an emotional and angry plea for the respondent to check on her grandmother, the respondent called the Rayne Police Department to report that the granddaughter was disturbing the residents of the facility. The respondent had the granddaughter escorted out of the facility by the police. After being escorted out of the nursing home, the resident's granddaughter called an ambulance to have the resident, Ms, Lavergne, sent to the Crowley American Legion Hospital.

According to the ambulance report, respiratory distress was noted as evidenced by the dyspnea (difficulty breathing) displayed by the resident and witnessed by the paramedics. The paramedics also noted that the patient, Ms. Lavergne, was complaining of "hurting all over" and shortness of breath. The assessment performed by the paramedics revealed vital signs as follows:

Blood pressure- 128 systolic and 94 diastolic

Pulse -- 106

Lung fields -- wheezing in the right lobe

Respirations - 28

(Record: Exhibit "E" at Pages 95-96, Acadian Ambulance Service Medical Record.)

***2** In addition, the EKG rhythm strip showed that Ms. Lavergne was experiencing atrial fibrillation (a cardiac arrhythmia marked by rapid and random contractions of the atrial myocardium). (See Record: Exhibit "F" at Page 132, American Legion Hospital Records.)

At the hospital, Ms. Lavergne was diagnosed with an acute myocardial infarction, pneumonia and sepsis. (See Record: Exhibit "F" at Page 102, American Legion Hospital Records.) Ms. Lavergne died the next day.

In her narrative statement responding to the complaint, the respondent denied the allegations. The respondent stated that a friend of the family of the resident approached the respondent and asked for the telephone number of the resident's daughter in-law. The respondent provided the requested telephone number. This family friend then told the respondent that she (the friend) was concerned about the resident's condition, and that the resident was "breathing strange". When the friend of the family asked the respondent to check on the resident, the respondent stated that she stopped what she was doing and went to the resident's room to assess the resident. The respondent noted the following in regard to the resident: Respirations were full, even, and unlabored. Breath sounds were bilaterally clear. Skin color was pink, warm, and dry. Resident denied pain. Bilateral radial pulses were palpable and normal, rate was within normal limits. The Respondent noted the resident's supper fray at her bedside

uncovered; and she encouraged the resident (Ms. Lavergne) to eat and the resident refused at that time, stating she would try to eat when she awakens from a nap.

In her statement, the respondent said that moments later the family friend returned to the respondent stating that the resident's daughter in-law was in the resident's room and wanted the respondent to check the resident again regarding the previous concerns. The respondent told the family friend that she found no acute ***3** distress during her assessment of the resident and assured the family friend that she would be back to the resident's room as soon as possible. Several minutes later the daughter in-law came to the nurse's station asking if the respondent had checked on the resident. The respondent stated that she informed the daughter in-law that the resident was not in distress. According to the respondent's statement, about 10-15 minutes later the resident's granddaughter walked to nurse's station screaming and yelling at the respondent and using profane language. The respondent called the Rayne Police Department and while the police escorted the granddaughter from the facility, the granddaughter continued with her emotional outburst and stated that if anything happed to her grandmother the respondent would be sued.

The respondent, an agency nurse (temporarily assigned to the facility) had not seen or cared for the resident prior to the incident that led the family to report the respondent to the board. The *respondent was not familiar with Ms. Lavergne or her baseline condition*. The respondent admitted in her narrative statement that she relied on the certified nursing assistants to check on Ms. Lavergne and to inform the respondent if anything abnormal occurred with the resident.

On the other hand, the family and friend of the resident were familiar with the resident; they obviously detected a change in the resident's condition and attempted to bring this to the attention of the respondent. The respondent, who was the staff nurse on duty assigned to care for Ms. Lavergne, did not perform a complete assessment of the resident (by failing to obtain vital signs); and the respondent was not responsive to the repeated attempts of the family and friend of the resident to bring to the attention of the nurse (the respondent) that something was wrong with the resident (Ms, Lavergne).

As set forth above, instead of listening to the concerns of Ms. Lavergne's significant others, the respondent told the family that nothing was wrong with the ***4** resident, and that the resident's granddaughter was disturbing the residents of the facility. Instead of listening to the concerns of the family and friend, the respondent had the granddaughter escorted out of the facility by the police. In an attempt to get help for her grandmother, the granddaughter then called 911 for an ambulance to have Ms. Lavergne sent to Crowley American Legion Hospital where Ms. Lavergne, was diagnosed with an acute myocardial infarction, pneumonia and sepsis. Ms. Lavergne died the next day.

In this case, the respondent, Erica George failed to adequately care for the resident in that Erica George did not complete an assessment of the resident. Ms. George did not obtain the resident's vital signs. In addition, Erica George failed to adequately care for and address the needs of the resident's family.

II. *PROCEDURAL HISTORY AND ACTION OF THE TRIAL COURT*

A Formal Hearing was held at the offices of the Board on June 28, 2007, to consider alleged violations of the following sections of the statutes/rules by the respondent:
The Louisiana Revised Statutes of 1950, Title 37, Chapter 11, Part II, Section 969 A. (4); 978; and

(f) Is guilty of unprofessional conduct; and

(g) Has violated any provisions of this Part. And

The Louisiana Administrative Code, Title 46, Part XLVII, Subpart 1, §§ 306 T.

8. being guilty of unprofessional conduct;

a. failure to practice practical nursing in accordance with the standards normally expected; and

b. failure to utilize appropriate judgment in administering nursing practice; and

g. improper use of drugs, medical supplies, or patients' records; and

i. falsifying records; and

j. intentionally committing any act that adversely affects the physical or psychosocial welfare of the patient; and

p. inappropriate, incomplete or improper documentation

The Respondent, Ericka George, LPN, attended the scheduled hearing, represented by her attorney, Michael Bienvenu, and gave sworn testimony. In addition, eight (8) other witnesses were called and testified under oath:
***5** 1. Amanda Johnson, granddaughter of the resident

2. Karen Constantin, daughter-in-law of the resident in question and mother of Amanda Johnson

3. Saundra Heinan, a friend of the family

4. Danielle Young, CNA, Rayne Guest House, Rayne, LA

5. Odalie Lawson, CNA, Rayne Guest House, Rayne, LA

6. Christine Simon, RN, DON, Rayne Guest House, Rayne, LA

7. Renalla Hebert, EMT, Acadian Ambulance Company

8. Frank Cramer, EMT, Acadian Ambulance Company

The Board, after reviewing the entire evidence, issued the following Conclusions of Law:
That the respondent is in violation of the Louisiana Revised Statutes of 1950, Title 37, Chapter 11 Nurses, Part II. Practical Nurses, Section 969 A. (4); 978; and

(f) Is guilty of unprofessional conduct; and

(g) Has violated any provisions of this Part.

As further defined in the Louisiana Administrative Code, Title 46, Part XLVII. Nurses, Subpart 1, Practical Nurses, Section 306 (T)

8. being guilty of unprofessional conduct;

b. failure to utilize appropriate judgment in administering nursing practice.

And, in Open Session, on August 17, 2007, the Board Ordered:
that the license of the respondent, Ericka George, license #XXXXXX, BE ISSUED A LETTER OF REPRIMAND FROM THE BOARD AND

1. The respondent must take and satisfactorily complete the following Board-approved courses: Assertiveness, Communication Skills in Nursing, Conflict Resolution Skills, Critical Thinking in Nursing, Legal and Ethical Dilemmas, Nursing Care of the **Elderly**, Patient Advocacy and Ethical Nursing Practice, and Stress Management. Respondent must submit evidence of said courses to the Board office prior to July 26, 2008.

2. The respondent is to be fined $500.00, payable by money order/cashier's check only for the violations detailed in the Conclusions of Law, payable within 90 days of receipt of this notice.

3. A hearing assessment fee of $500.00, payable by money order/cashier's check only is to be submitted to the Board within 90 days of receipt of this notice.

(See Board Order dated 8/17/07 at Page 8 of Plaintiff's Exhibit “B” filed in the district court below.)

Ms. George paid the hearing assessment fee and the fines assessed by the Board back in 2007; and the Board has forwarded correspondence to Ms. George acknowledging payment and Ms. George's satisfactory completion of the required courses she was ordered to complete as part of the discipline imposed by the Board in this case.

***6** In her Findings of Fact and Conclusions of Law, the Hearing Officer, Ms. Patricia Juneau (who is a Registered Nurse and a member of the State LPN Board) noted: During the course of the formal hearing, the following facts were confirmed through live testimony of the witnesses:
A family friend who had dropped by the Nursing Home to visit the resident notified the family that she did not find the resident was doing well. The granddaughter and her mother, the respondent's daughter-in-law, immediately went to the Nursing Home.

The granddaughter, soon after her arrival, came to the nursing station and was cursing loudly, and was apparently totally out of control.

The respondent was unable to get her to listen to her as she tried to explain she HAD checked her grandmother and found no cause for undue concern at that time. Please refer to Exhibit G which contains the Nurse's Bedside Record as recorded by the respondent on July 30, 2006.

She also tried to explain to the granddaughter that she had just come on duty at 2:30 pm.

Because of the continuing irate behavior of the granddaughter in the hall at the nurses' station, the respondent warned her that if she could not settle down, she would have to call the police and have HER escorted from the building.

The irate behavior of the granddaughter DID CONTINUE and the respondent DID CALL THE POLICE and had the granddaughter ONLY escorted from the building.

The resident was subsequently transferred to the hospital following an OFF-SITE 911 CALL made by the GRANDDAUGHTER, Amanda Johnson.

The ambulance arrived. The respondent reported to and assisted the paramedics in preparing and executing the transfer of the resident to the hospital.

Exhibit G indicates the respondent left the Nursing Home via ambulance at 6:45 pm.

After the ambulance left with the resident, the respondent did call the Emergency Room of the hospital and advised staff that a police officer might need to be present when the family arrived, based on the behavior of the granddaughter at the Nursing Home. A police officer was dispatched to the Emergency Room.

The resident was transferred to the American Legion Hospital in Crowley and subsequently died.

Exhibit F contains the records of the resident while at the American Legion Hospital.

The resident in this incident, was an 88 year-old female who was residing at Rayne Guest House in Rayne, LA.

According to the Death Summary form of the American Legion Hospital Crowley, LA, the following facts describe her status from her admission to her death:

***7** At 1942 [7:42 p.m.] on July 30, 2006, she was received in the Emergency Room of American Legion Hospital from the Nursing Home because of shortness of breath and some wheezing. She had become restless. She had a history of hypertension, peripheral vascular disease, gangrenous changes to the left lower extremity, type II diabetes, and chronic renal failure. She had some pulmonary edema on admission and her cardiac enzymes rose to a peak of a troponin of 30.7, CK was 260. The patient developed lethargy and hypotension. The family wanted no resuscitative efforts and her preexisting no code status was affirmed. She became apneic and pulseless and was pronounced dead at 1430 on July 31, 2006.

Primary cause of death was Subendocardial Infarction, initial episode of care. Secondary Diagnoses included Cardiogenic shock; Gangrene, Decubitus ulcer heel; Hypertensive kidney disease, unspecified benign or malignant with chronic kidney disease; Diabetes Mellitus with peripheral circulatory disorder, Type II or unspecified type, not stated as; Peripheral Vascular Disease, unspecified.

Please refer to Exhibit F.

The sworn testimony of the granddaughter (Amanda Johnson whose testimony is recorded on Pages 4-46 of the Hearing Transcript), the daughter-in-law (Karen Constantin whose testimony is recorded on Pages 47 - 79 of the Hearing Transcript), and the family friend (Saundra Heinan whose testimony is recorded on Pages 79 - 105 of the Hearing Transcript) all indicate the concerned AND out-of-control behavior of the family during this time of great stress with their loved one.

Sworn testimony of AGENCY PERSONNEL and their written narratives all confirm the very out-of-control behavior of the granddaughter, Amanda Johnson, toward the respondent as well as exhibited by the loud, uncontrolled screaming and cursing she engaged in the hall at the nurses' station.

Their testimony ALSO supports the validity of the nurses' notes of the respondent as well as the testimony and written response of the respondent which indicates the respondent DID assess the status of the resident, WHOM IT WAS THE RESPONDENT'S FIRST DAY TO CARE FOR, on multiple occasions, but NOT on the EXACT TIMETABLE DEMANDED by the granddaughter, the daughter-in-law, and the family friend, due to the needs of her other patients that afternoon.

Please refer to the sworn testimony of:

**Danielle Young, CNA which is recorded on Pages 216 - 227 of the Hearing transcript.

** Odalie Lawson, CNA, who ALSO SUPPORTS the fact that the granddaughter called the respondent “A BLACK BITCH” and is recorded on Pages 227 - 238 of the Hearing Transcript; and

Christine Simon, RN, DON, whose sworn testimony on Pages 238 - 245 of the Hearing Transcript indicates the respondent performed correctly, EXCEPT **FOR her failure to record some vital signs she stated she had taken on the resident.

The Hearing Officer did find that the respondent is guilty of unprofessional conduct (failure to utilize appropriate judgment in administering nursing practice) in her lack of insight into the emotional needs and inadequate emotional support of the family of a resident who was experiencing a crisis.

(See Board Order dated 8/17/07 at Page 6 of Plaintiff's Exhibit “B” filed in the district court below.)

Thus, **the Hearing Officer and the Board specifically noted:**

> **Christine Simon, RN, DON, whose sworn testimony on Pages 238 - 245 of the Hearing Transcript indicates the respondent performed correctly, EXCEPT FOR her failure to record some vital signs she stated she had taken on the resident.**

***8** (See Board Order dated 8/17/07, and Findings of Fact and Conclusions of Law at Page 5 of Plaintiffs Exhibit “B”.) (Emphasis in original.) Moreover, **the Board and the Hearing Officer specifically noted** that:
... according to the ambulance report, respiratory distress was noted as evidenced by the dysp[n]ea displayed by the resident and witnessed by the paramedics. They also noted that the patient was complaining of “hurting all over” and shortness of breath. The assessment they performed revealed vital signs as follows:

Blood pressure -- 128 systolic and 94 diastolic

Pulse -- 106

Lung fields -- wheezing in the right lobe

Respirations -- 28

(See Board Order dated 8/17/07, and Findings of Fact and Conclusions of Law at Page 2 of Plaintiff's Exhibit “B”.) (Emphasis added.)

On June 2, 2010, the Civil District Court, the Honorable Piper D. Griffin presiding, affirmed the Order of the LPN Board dated August 17, 2007.

III. ISSUE PRESENTED FOR REVIEW

Whether or not, given the jurisprudential presumption of correctness of an agency's actions, the appellant, who has the burden of proving the record contains no facts to establish the validity of the charges levied against her as required by *Armstrong v. Louisiana State Board of Medical Examiners*, 868 So.2d 830, 838 (La. App. 4th Cir. 2004), has failed to carry her burden of proving: 1) the record contains no facts to establish the validity of the charges levied against her, based upon a review of the entire record in this case; and 2) that the trial court committed legal error and abused its discretion in upholding the Board's decision where the Board's decision in this case, based on the entire record, is supported by a preponderance of the evidence.

9 IV. *LAW AND ARGUMENT

A. The Plaintiff-Appellant, Ericka George, failed to carry her burden of proving the record reviewed by the district court contains no facts to establish the validity of the charges levied against her; and, she has also failed to prove that the trial court committed legal error and abused its discretion in upholding the Board's decision in this case, where the Board's decision, based on the entire record, is supported by a preponderance of the evidence.

The "standard of appellate review of a decision by an administrative agency is distinct from and narrower than that which pertains to general appellate jurisdiction over civil and criminal appeals." *Reaux v. Louisiana State Board of Medical Examiners*, 850 So.2d 723, 726 (La. App. 4th Cir. 2003); citing *Holladay v. Louisiana State Board of Medical Examiners*, 689 So.2d 718 (La. App. 4th Cir. 1997), *writ denied*, 693 So.2d 740. Moreover, "[c]onsiderable latitude must be afforded administrative agencies to perform the functions delegated to them under the law, and courts should not intervene unless the administrative agencies' conduct is clearly unreasonable and arbitrary .... An administrative agency's proceedings and decisions are presumed to be legitimate and correct, and the burden is on the appellant to demonstrate the grounds of reversal or modification." *Reaux v. Louisiana State Board of Medical Examiners, Id*. And, "fw]here the administrative agency has had the opportunity to judge the credibility of witnesses by first-hand observation of demeanor on the witness stand and the reviewing court does not, due regard shall be given to the agency's determination of credibility issues." *Id*, at 726, citing LSA-R.S. 49:964(G). Accordingly, the scope of judicial review of actions taken by an administrative agency is limited to a determination of whether the decision was "unreasonable, arbitrary, or capricious," or amounted to an abuse of discretion.

Further, in reviewing such actions, courts must be cognizant of a strong presumption of validity and propriety in such administrative actions where casting ***10** judgment on the professional behavior of a fellow member of a profession is a matter peculiarly within the expertise of the agency composed of members of that profession. *Matter of DiLeo*, 661 So.2d 162 (La. App. 4th Cir. 1995); See also, *Davis v. Louisiana State Board of Nursing*, 691 So.2d 170 (La. App. 1st Cir. 1997). Therefore, courts should not intervene unless the administrative agency's conduct is unreasonable and arbitrary, particularly where the board [or the hearing officer] has had the opportunity to observe the witnesses, as in this case. *Reaux v. Louisiana State Board of Medical Examiners, Id*.

On judicial review of an agency's decision, the board's decision must be supported by a preponderance of evidence. La. Rev. Stat. Ann. § 49:964(G)(6) (West 2003 and West Supp. 2006). Nonetheless, the reviewing court shall give due regard to the agency's, or hearing officer's, ability to judge the credibility of the witnesses by first-hand observation of the demeanor of the witnesses. La. Rev. Stat. Ann. § 49:964(G)(6) (West 2003 and West Supp. 2006). *Cathey v. LA State Racing Commission*, 855 So.2d 414 (La. App. 4th Cir. 2003).

In this case, the decision of the Board is clearly supported by a preponderance of evidence as required by Louisiana Revised Statutes, § 49:964(G)(6). See, La. Rev. Stat. Ann. § 49:964(G)(6) (West 2003 and West Supp. 2006); See also, *Cathey v. LA State Racing Commission*, 855 So.2d 414 (La. App. 4th Cir. 2003).

The Respondent contended in the district court below: "The Board's decision was not supported by any evidence much less a preponderance of the evidence." (See Petitioner's brief, filed in the district court below, at page 16, No. 1.) In support of her contention, the Respondent incorrectly asserted that "there is *no* evidence in this record to substantiate that Ms. Lavergne (i.e. 'the resident') was 'experiencing a crisis' at any time prior to leaving the Rayne Guest House." (See Petitioner's brief, filed in district court below, at page 16.) (Emphasis in original.) ***11** In doing so, the Respondent chose to ignore *the documented facts*, **noted in the Hearing Officer's Findings of Fact** that:
"... according to the **ambulance report,** *respiratory distress was noted* as ***evidenced by the dyspnea displayed by the resident and witnessed by the paramedics***. They also noted that ***the patient was complaining of "hurting all over" and shortness of breath***. The assessment they performed revealed vital signs as follows:

Blood pressure - 128 systolic and 94 diastolic

Pulse -- 106

Lung fields -- wheezing in the right lobe

Respirations - 28

(Hearing Officer's Findings of Fact at Page 2. Petitioner's Brief, filed in the district court below - Exhibit "B".) (Emphasis supplied.)

Moreover, **the Board and the Hearing Officer specifically noted** that:
****Christine Simon, RN, DON, whose sworn testimony on Pages 238 - 245 of the Hearing Transcript indicates the respondent performed correctly, EXCEPT FOR her failure to record some vital signs she stated she had taken on the resident.**

(See Board Order dated 8/17/07, and Findings of Fact and Conclusions of Law at Page 5 of Plaintiffs Exhibit "B".) (Emphasis in original.)

The Petitioner herself acknowledges in her Original Brief (at Page 1) that the Formal Complaint in this case DID allege that Ms. George "failed to do a thorough assessment by failing to include vital signs." (See Petitioner's Original Brief at Page 1, Section A, entitled: "The Complaint Allegations and Charges.") Moreover, the Appellant, Ericka George, acknowledged under oath, the accuracy of the allegation(s), that she did not perform a thorough assessment to include vital signs, admitting: "I did not check ... blood pressure or temp, so it wouldn't be a full set of vital signs." (See Transcript of Formal Hearing at page 150, Lines 4-11.)

This was supported by the sworn testimony of Ms. Christine Simon, RN, the Director of Nurses, whose sworn testimony (referenced above) appears on Pages 238 - 245 of the Hearing Transcript; and Ms. Simon's sworn testimony was found to be credible by the Hearing Officer, Ms, Patricia Juneau, who is also a Registered Nurse. (See Board Order dated 8/17/07, and Findings of Fact and Conclusions of ***12** Law at Page 2 of Plaintiff's Exhibit "B".) Accordingly, this Court should not intervene unless the administrative agency's conduct is unreasonable and arbitrary, particularly where the board [or the hearing officer] has had the opportunity to observe the witnesses, as in this case. *Reaux v. Louisiana State Board of Medical Examiners, Id.*

The Appellant (at page 22 of her brief filed in this Court) cites *Cranford v. Louisiana State Board of Practical Nurse Examiners*, 966 So.2d 590, 602 (La App. 4th Cir. 2008), where the LPN Board had revoked the Louisiana LPN license of Melanie Cranford, and this Court affirmed the district court's ruling that the evidence in the record was sufficient to establish that the LPN had engaged in negligent and abusive behavior. The Appellant contends: "The Board's decision was clearly arbitrary, capricious, an abuse of discretion, and an unwarranted exercise of discretion;" and she cites *Cranford, Id.*, where this Court stated: An administrative decision is **arbitrary when** the **administrative agency has disregarded evidence** or given inappropriate weight to evidence; the decision is **capricious when the agency's conclusion has no substantial basis or is contrary to substantiated competent evidence**.

Cranford, Id., at 602. (Emphasis added.) (See also Appellant's Brief at Page 22.)

Next, the appellant notes that the Hearing Officer found Ms. Johnson not credible and the reliability of the testimony of Ms. Constantin and Ms. Heinan to be strongly questionable; and then the appellant either incorrectly concludes, or worse, misrepresents to this Court, that "the only evidence on which 'unprofessional conduct' finding was predicated could only have been the Nurse's Bedside Record, the testimony of Ms. George, and the testimony of the only other witnesses to the incident, CNA Lawson and CNA Young. (See Appellant's Brief at Page 22.)

That statement by the Appellant either conveniently forgets, or worse yet, obfuscates the clear fact that there were *three additional witnesses* who also testified at the Formal Hearing, namely: Renalla Hebert, EMT, Frank Cramer, EMT, and ***13** Ms. Christine Simon, R.N., the Director of Nurses at Rayne Guest House, whose testimony (at Page 239, Lines 16-22) criticizes the fact that Ericka George failed to take the resident's vital signs (one of the most basic and critical procedures in nursing care, particularly in dealing with the **elderly**). Ms. Simon's testimony, in fact, corroborates the testimony of Ms. George herself, wherein Ms. George actually agreed with the allegation that she did not perform a thorough assessment to include vital signs, admitting: "I did not check ... blood pressure or temp, so it wouldn't be a full set of vital signs." (See Transcript of Formal Hearing at page 150, Lines 4-11.) This admitted fact alone supports the finding of "unprofessional conduct," about which the Appellant claims: "[t]he Board's decision was not supported by any evidence much less a preponderance of the evidence." (See Petitioner's brief, filed in the district court below, at page 16, No. 1.)

Oddly enough, the Appellant (at Page 16 of her brief filed in this Court) acknowledges that, in fact, an R.N. (whom the appellant does not identify, but who clearly is Christine Simon, R.N., the Director of Nurses at Rayne Guest House) did testify about Ericka George's "failure to document some vital signs;" but then claims that the Hearing Officer "took no issue with" those facts. (See Appellant's brief at Page 16.) However, *the Hearing Officer specifically noted* **in boldface type** (at page 6 of her Findings of Fact) the testimony of Christine Simon, R.N., DON, indicating that Ericka George "**fail [ed] to record some vital signs she stated she had taken on the resident**" And the Hearing Officer notes this immediately before she finds the respondent, Ericka George, **"guilty of unprofessional conduct**." (See Hearing Officer's Findings of Fact at Pages 6-7.)

Furthermore, it is a basic premise and belief of the nursing profession is that the nurse's client includes "individuals, families and significant others" (NCLEX-PN Test Plan, 2005 at page 7.) And, caring is a process that is fundamental to the ***14** practice of practical nursing. Caring is defined as the "interaction of the practical/vocational nurse and clients, families, and significant others in an atmosphere of mutual respect and trust." (NCLEX-PN Test Plan, 2005 at page 9.)

Dealing with emotional clients is part of the daily practice of practical nursing. Practical nursing education programs teach therapeutic communication skills that nurses use in order to de-escalate and defuse situations exactly like that which occurred in this case. Therapeutic communication includes providing emotional support to clients (page 30 of the NCLEX-PN Test Plan). "Therapeutic verbal communication is extremely important, especially when ... exploring problems...." (*Fundamental Nursing Skills and Concepts*, Barbara K. Timby, 9th Ed., 2009, Lippincott Publishing, pg. 96.)

It is not unusual for family members to become angry and emotional when facing the declining health status of a loved one. Ms. George failed to utilize her basic nursing knowledge when she failed to employ the techniques of therapeutic communication. Therapeutic communication employs the use of "scripted" format and calls for the nurse to do and say certain things in response to an emotional outburst similar to that displayed by the granddaughter of Ms. Lavernge. First, the nursing script calls for the nurse to move a difficult conversation to a private place. In this case, Ms. George should have walked with the "irate" family member to the conference room or more preferably back to the resident's room. Then the script calls for the nurse to allow the family to express their emotions and concerns in a non-judgemental atmosphere.

"Nurses must approach vocal, emotional clients delicately. For instance when clients are angry or crying, the best nursing response is to allow them to express their emotion. Allowing clients to display their feelings without fear of retaliation or censure contributes to a therapeutic relationship." (*Fundamental* ***15** *Nursing Skills and Concepts*, Barbara K. Timby, 9th Ed., 2009, Lippincott Publishing, pg. 96.)

It was the responsibility of Erica George to utilize her nursing knowledge and skills to care for the resident and the resident's family. It was the responsibility of Erica George to establish a therapeutic relationship with the resident's family. "The amount of time a person must wait after seeking attention is important. Delays in response to a ...direct request from a person may be interpreted as a lack of concern, even if this is not intended. The response to this perception may manifest in anger, displeasure, anxiety, fear, and many other feelings." (*Basic Geriatric Nursing*, Gloria Wold, pg. 90. Published by Mosby, Inc. 2008). In

this case, and in similar cases where a family member is dying, family members may become angry and emotional - especially if they feel that their loved one is being **neglected** or ignored. It is the responsibility of the practical nurse to establish and maintain a therapeutic relationship.

The Hearing Officer (who is a Registered Nurse) and the Board Members (Medical Doctors, Registered Nurses and Licensed Practical Nurses) are all members of the medical profession; and as medical professionals, [1] it is well known to all of the members of the Board that: "Nurses must be prepared to interact with their patient's friends, families, and other visitors....Families and friends are interested and concerned about what is happening to their loved ones.... they can also be a good source of information for the nurse. These significant others, as they are often called, can help in many ways if nurses are responsive to them....Because they have known the patient longer and better than the nursing staff has, they are often able to detect subtle changes before trained nurses can. Many times, nurses ***16** need to relay on the significant others to interpret the behaviors and communications of older adults. Listen to what they have to say." (*Basic Geriatric Nursing*, Gloria Wold, pg. 96. Published by Mosby, Inc. 2008).

The Appellant, in her brief, goes to great lengths attempting to misdirect this Court's attention toward the conduct of Ms. Amanda Johnson (the **elderly** resident's granddaughter) in an obvious attempt to deflect this Court's attention from the *only* relevant issue in this case: namely whether the record as a whole supports the Board's finding of "unprofessional conduct" on the part of the Appellant, Ericka George, LPN. In fact, it appears that the Appellant would rather this Court focus on the acknowledged confrontational and emotionally charged conduct of a deeply concerned relative of the Resident of the Rayne Guest House nursing facility, [2] as if this would somehow exonerate her from her own admitted failure to fully take the **elderly** resident's vital signs, **neglecting** to take either the resident's blood pressure or temperature, even though the resident's granddaughter was "making a scene" in an attempt "to get help" for her grandmother.

However, the conduct of the concerned relative is not at issue in this case. As per this Court's directive in *Armstrong v. Louisiana State Board of Medical Examiners*, 868 So.2d 830, 838 (La. App. 4th Cir. 2004), the *only issue* is whether the Appellant, Ericka George, has carried her "burden of proving the record contains no facts to establish the validity of the charges levied against h[er]," based upon a *review of the entire record* in this case - and that the trial court committed legal error and abused its discretion in upholding the Board's decision where the Board's decision, based *on the entire record*, is supported by a preponderance of the evidence.

***17** The record in this case clearly demonstrates that the Appellant has not, because she cannot, based on the evidence in this case, carry her burden of proving the record contains no facts to establish the validity of the charges levied against her in this case. Quite to the contrary, a *review of the entire record* in this case demonstrates that the decision of the Board is clearly supported by a preponderance of evidence as required by Louisiana Revised Statutes, § 49:964(G)(6). See, La. Rev. Stat. Ann. § 49:964(G)(6) (West 2003 and West Supp. 2006); See also, *Cathey v. LA State Racing Commission*, 855 So.2d 414 (La. App. 4th Cir. 2003).

Moreover, neither the court of appeal nor the trial court sitting as the reviewing court is empowered to substitute its judgment for that of the administrative agency if the agency's decision has a rational basis and is supported by sufficient relevant and admissible evidence. *Davis v. Louisiana State Board of Nursing*, 691 So.2d 170 (La. App. 1st Cir. 1997), *wit denied*, 692 So.2d 1094 (La. 1997). And this Court must be cognizant of a strong presumption of validity and propriety in such administrative actions where casting judgment on the professional behavior of a fellow member of a profession is a matter peculiarly within the expertise of the agency composed of members of that profession. *Matter of DiLeo*, 661 So.2d 162 (La. App. 4th Cir. 1995); See also, *Davis v. Louisiana State Board of Nursing*, 691 So.2d 170 (La. App. 1st Cir. 1997).

It has been held that the imposition of an administrative sanction is in the nature of a disciplinary measure and in deciding what, if any, discipline to impose, an administrator or administration may, within the range of permissible discretionary limits, be strict, moderate or lenient and, unless arbitrary, such discretion or a decision must be upheld. *Mayeaux's Food and Sporting Goods, Inc. v. State Department of Health and Human Resources*, 470 So.2d 469 (La. App. 1st Cir. 1985). And a reviewing

court should not set aside an administrative agency's ***18** decision to impose a particular sanction unless that decision can be characterized as arbitrary, capricious, or an abuse of discretion. *Rabb v. State Board of Certified Public Accountants of Louisiana*, 893 So.2d 904 (La. App. 4th Cir. 2004), *writ denied*, 896 So.2d 1045 (La. 2005).

In this case, Ms. George was issued a "Letter of Reprimand" on August 17, 2007. She has paid the hearing assessment fee and the fines assessed by the Board back in 2007; and the Board has forwarded correspondence to Ms, George acknowledging payment and Ms. George's satisfactory completion of the required courses she was ordered to complete as part of the discipline imposed by the Board.

The decision of the Board in this case, based upon the entire record, is clearly supported by a preponderance of evidence as required by Louisiana Revised Statutes, § 49:964(G)(6). See, La. Rev. Stat. Ann, § 49:964(G)(6) (West 2003 and West Supp. 2006); See also, *Cathey v. LA State Racing Commission*, 855 So.2d 414 (La. App. 4th Cir. 2003). Therefore, the decision of the Louisiana State Board of Practical Nurse Examiners should be upheld; and it should not be altered or amended in any way, as it is supported by a preponderance of the evidence, and in no way, is arbitrary, capricious, or unsupported by the evidence adduced at the formal hearing held in this case.

V. *CONCLUSION*

The Louisiana State Board of Practical Nurse Examiners, whose mission is to protect the public health and welfare through regulation of practical nursing education and practice, respectfully suggests that, contrary to the contentions of the Appellant, a *review of the entire record* in this case demonstrates that the decision of the Board is clearly supported by a preponderance of evidence as required by Louisiana Revised Statutes, § 49:964(G)(6). *See*, ***19** La. Rev. Stat. Ann. § 49:964(G)(6) (West 2003 and West Supp. 2006). The decision of the Board is well supported by a preponderance of the evidence as set forth in the record in this case; and the decision, findings and conclusions of the Board in this case are fully supported by the record. Therefore, for the reasons set forth herein, the Judgment of the Civil District Court for the Parish of Orleans, dated June 2, 2010, upholding the August 17, 2007 Order of the Board, should be affirmed.

Moreover, the Board's decision should not be altered or amended in any way, as it is supported by a preponderance of the evidence; and the Board's decision is in no way, arbitrary, capricious, or unsupported by the evidence adduced at the formal hearing held in this case. Therefore, for the reasons set forth herein above, the Louisiana State Board of Practical Nurse Examiners respectfully suggests that the ruling of the district court below, affirming the decision of the Board should be affirmed without being altered or amended in any way.

V. *PRAYER*

For the reasons set forth herein above, The Louisiana State Board of Practical Nurse Examiners, respectfully prays: that the Judgment of the Civil District Court for the Parish of Orleans, dated June 2, 2010 (affirming the August 17, 2007 Order of the Board), be affirmed.

Footnotes

1 In *Reaux v. Louisiana State Board of Medical Examiners*, 850 So.2d 723, 726 (La. App. 4th Cir. 2003), *rehearing denied*, *writ denied*, 860 So.2d 1138 (2003), this Court of Appeal held: The Board of Medical Examiners is made up of physicians and is able to evaluate medical issues without the assistance of expert testimony for purposes of a physician disciplinary proceeding.

2 Ms. Amanda Johnson, the **elderly** resident's granddaughter) freely admitted at the Formal Hearing that "I made a scene because **I was trying to get help**" and that she "**made a point to let it be known that I needed help**." (See Formal Hearing Transcript at Page 31. Lines 8-16.) (Emphasis supplied.)

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